

This form can be completed on your computer, then faxed to Alabama Medicaid.

## Pharmaceutical Manufacturer Contact Information Form

Please designate one individual as the contact person for your company for the purposes of correspondence and notice for the Preferred Drug Program. Manufacturers are responsible for updating contact information as needed.

Company Name \_\_\_\_\_

Contact Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone # (      ) \_\_\_\_\_

Fax # (      ) \_\_\_\_\_

Email \_\_\_\_\_

Date Submitted \_\_\_\_\_

Please type or print legibly and fax completed form to:  
Alabama Medicaid Agency/Pharmacy Program @ 334-353-7014